CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

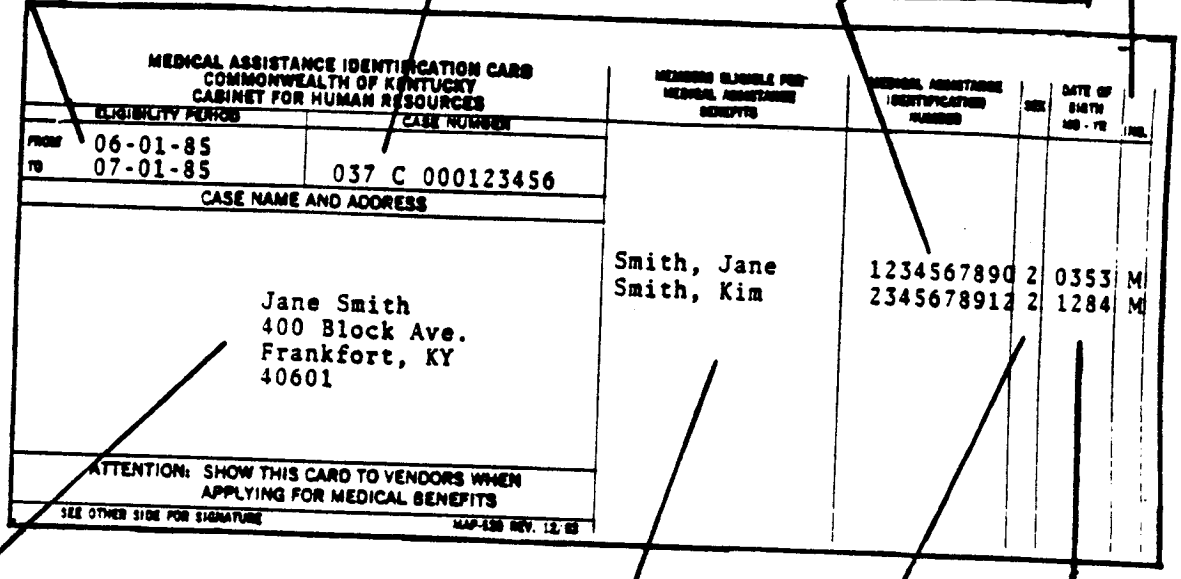
(FRONT OF CARD)

Eligibility Period is the month, day and year of KMAP eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Medical Insurance Code indicates type of insurance coverage.-

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.



MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD		CASE NUMBER	MEMBERS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS	MEDICAL ASSISTANCE IDENTIFICATION NUMBER	SEX	DATE OF BIRTH MO - YR	INS.
FROM	06-01-85						
TO	07-01-85	037 C 000123456					
CASE NAME AND ADDRESS							
Jane Smith 400 Block Ave. Frankfort, KY 40601			Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS
SEE OTHER SIDE FOR SIGNATURE
MAP-130 REV. 12/85

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Names of members eligible for Medical Assistance Benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits

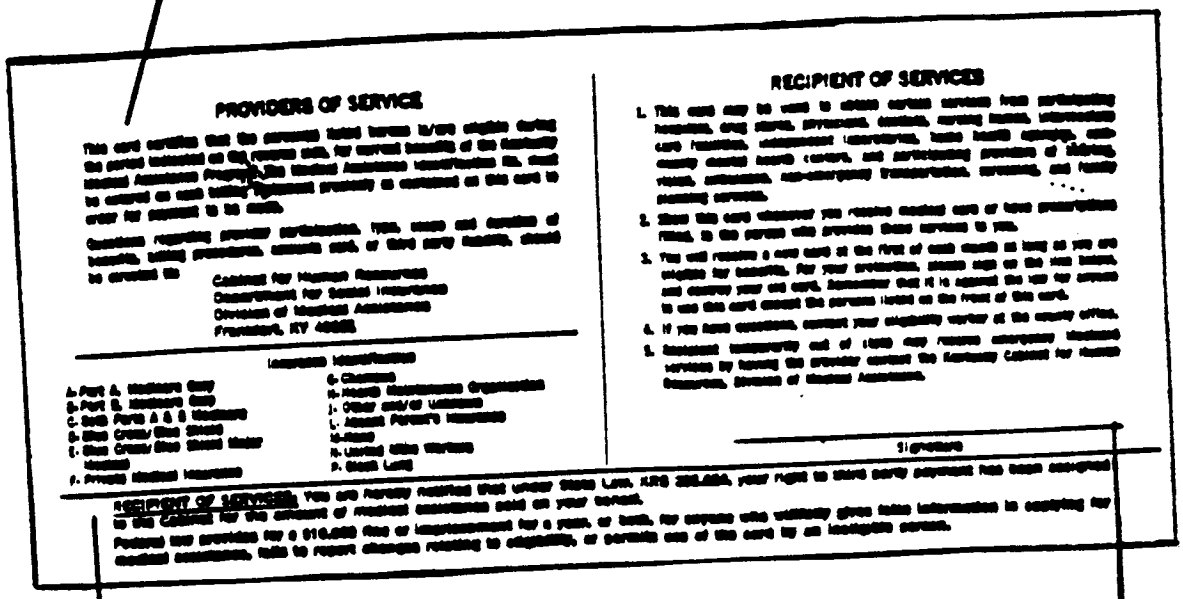
Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

APPENDIX II-B

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Eligibility Period, month, day, and year. "From" date is first day of eligibility certified by this card. "To" date is the day that eligibility ends, and is not included in the eligibility period represented by this card.

Name and license number of lock-in physician. Once the designated providers have been selected, KMAP payments will be limited to those providers, unless otherwise authorized by the KMAP (with the exception of emergency services and physician referrals).

M.A.I.D. Number for medical service billing on provider invoices. This is a 10 digit number.

Record of visits to be recorded on the lock-in card by the physician's office at the time service was rendered.

MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

ELIGIBLE RECIPIENT & ADDRESS

Public, John Q.
1791 Kentucky Street
Frankfort, KY 40601

ELIGIBILITY PERIOD
FROM 050185
TO 060185

MEDICAL ASSISTANCE IDENTIFICATION NUMBER
1234567890

SEX CODE

INSURANCE
D

DATE OF BIRTH MONTH / YEAR

CASE NUMBER
0037

PHYSICIAN NAME
E. Smith, M.D. 12345

LICENSE NO.

RECORD OF VISITS
1 3
2 4

PHARMACY NAME
Capital Drugs 23451
Elkhorn Avenue
Frankfort, Ky. 40601

SEE OTHER SIDE FOR SIGNATURE

MAP-528A REV 10/84

Currently Left Blank

Medical Insurance Code

Identifies type of case and county of residence.

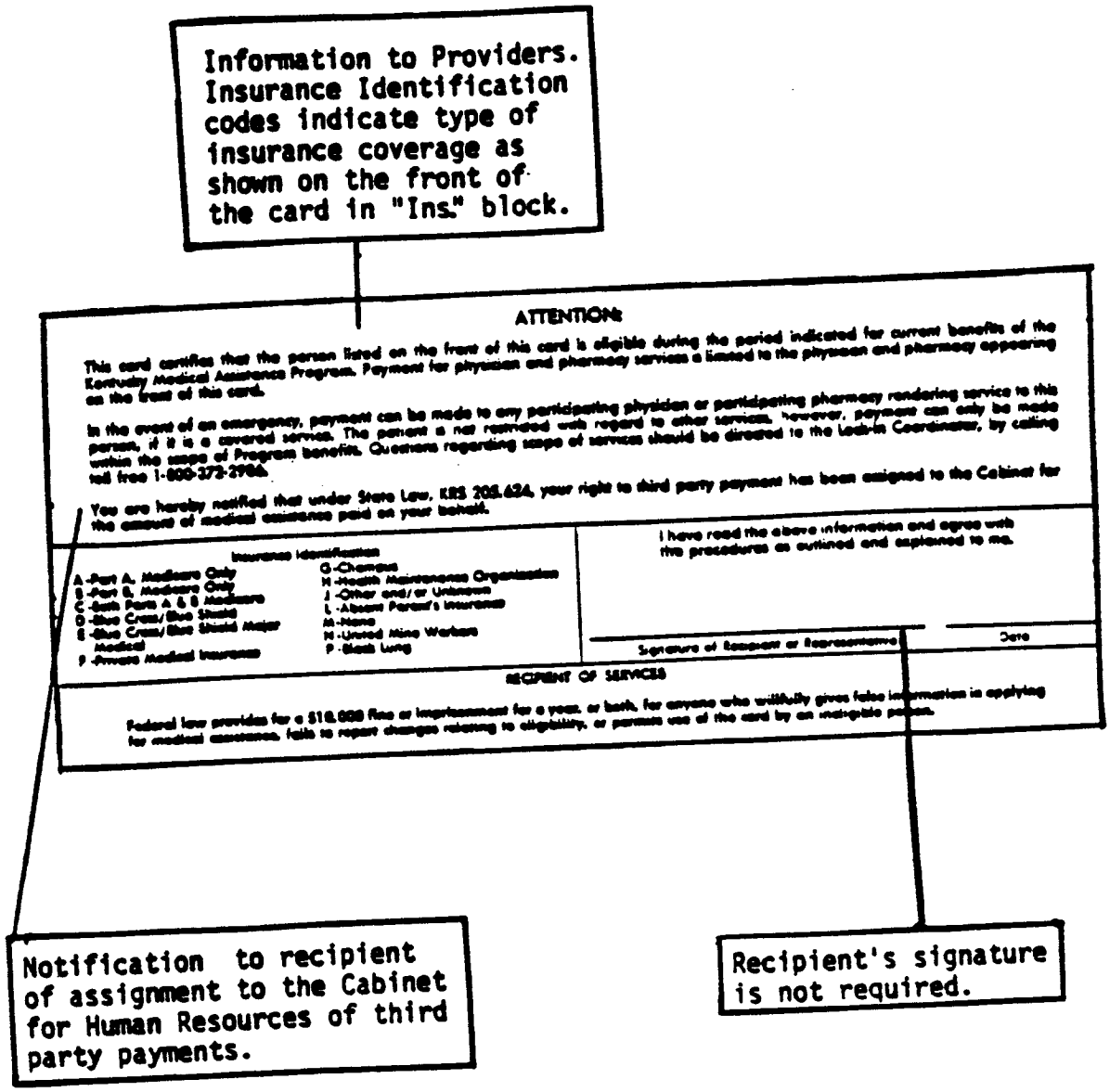
Name and address of member eligible for Medical Assistance benefits. All eligible individuals within a given household will receive a separate card.

Name, license number and address of lock-in pharmacy. Payment for pharmacy services is limited to the named pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)



MAP-343 (Rev. 5/86)

Provider Number: (If Known) _____ APPENDIX III

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

/_/ Corporation (Public) /_/ Individual Practice /_/ Hospital-Based Physician

/_/ Corporation (Private) /_/ Partnership /_/ Group Practice

/_/ Health Maintenance Organization /_/ Profit /_/ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____

2nd _____ Date: _____

3rd _____ Date: _____

22. Name of Clinic(s) in Which Provider is a Member:

1st _____

2nd _____

3rd _____

4th _____

23. Control of Medical Facility:

/_/ Federal /_/ State /_/ County /_/ City /_/ Charitable or Religious

/_/ Proprietary (Privately owned) /_/ Other _____

24. Fiscal Year End: _____

25. Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and telephone number of owner:

Name: _____

Address: _____

Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

	Name	Address
President or Chairman of Board:		
Member:		
Member:		
Member:		
Member:		

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospital TB/Upper Respiratory Disease		
Skilled Nursing Facility		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

Name	Address	Percent of Ownership

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation:_____ No. of Wheelchair Vans in Operation:_____

Total No. of Employees:_____ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____

D. Extra Patient $_____

E. Other

_____ $_____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical Assistance Program.

Signature: _____

Name:_____

Title:_____ Date:_____

INTER-OFFICE USE ONLY

License Number Verified through_____(Enter Code)

Comments:_____

_____

Date:_____ Staff:_____

KMAP
STATEMENT OF ON-SITE SERVICES
AND REFERRAL ARRANGEMENTS

This is to certify that _____,
(Facility Name)

_____,
(Address, City, State and Zip Code)
in applying for participation in the Kentucky Medical Assistance Program to provide medical services to eligible Title XIX recipients, agrees to provide the following basic and supplemental services at the facility site in accordance with the requirements of State Regulations.

List all services that will be provided (i.e. Medical, Dental, Optometric, Pharmacy, Laboratory, etc.):

SERVICE	STAFF MEMBER	LICENSE NUMBER/DEGREE

MAP-346
(8/82)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals is currently entered into financial arrangements with _____ (Facility Name) _____ (City) _____ (State), for the purpose of rendering his/her special services to patients of this facility, and that currently on file in this care center is a Statement of Authorization executed by each of these individuals which authorizes payment by the KMAP to the _____ (Facility Name) for services rendered eligible Program beneficiaries.

NAME	LICENSE NUMBER	POSITION (Physician, Psychiatrist, etc.)	DATE OF CENTER EMPLOYMENT

Signed _____
Facility Administrator

MAP-347
(02/86)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION

I hereby declare that I, _____,
(Licensed Professional)

a duly-licensed _____, have entered into a

contractual agreement with _____
(Clinic/Corporation or Facility Name)

_____
(City, State, & Zip Code)

to provide professional services. I authorize payment to

_____
(Clinic/Corporation or Facility Name)

from the Kentucky Medical Assistance Program for covered services provided by me and specified by the criteria of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is

reimbursed to _____
(Clinic/Corporation or Facility Name)

as part of our contractual agreement, and that I am solely and completely responsible for all Kentucky Medical Assistance Program documents submitted by this employer in my name for services I provided.

_____ _____
Signature of Professional Date Signed

_____ _____
License and/or Certification Number Specialty

_____
Social Security Number

_____
Federal Employer Identification Number

_____
KMAP Provider Number of
Clinic/Corporation or Facility

MAP 7 (10/86)

EDS
P.O. Box 2064
Frankfort, KY 40602

COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT

PRIMARY CARE/RURAL HEALTH

Do not write in this area

RECIPIENT LAST NAME	2. FIRST NAME	3. M.I.	4. MEDICAL ASSISTANCE I.D. NUMBER

5. ☐ IF EMERGENCY CHECK BOX	6. If Claim Required A Prior Authorization, Enter The Prior Authorization Number Here	7. If Services Were Provided As A Result of A Screening Exam Referral, Check Box ☐	8. If Patient Was Referred To You, Enter The Name of The Referring Practitioner.

9. IF PATIENT HAS HEALTH INSURANCE, ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBER. — LEAVE BLANK

10. (1) FIRST DIAGNOSIS:

(2) SECOND DIAGNOSIS:

11. INDICATE SERVICE BY ENTERING APPROPRIATE CODE (SEE MANUAL)
- ☐ General Health Assessment and Patient History
- ☐ Development Assessment
- ☐ Visual Screening
- ☐ Audiometric Screening
- ☐ Dental Screening
- ☐ Urinalysis
- ☐ Tuberculosis Test
- ☐ Hematocrit or Hemoglobin
- ☐ Lead Poisoning
- ☐ Other (Specify)

12. INDICATE SPECIAL TESTS BY ENTERING APPROPRIATE CODE (SEE MANUAL)
- ☐ Assessment and Administration of Vaccines and Immunizations
- ☐ Blood Pressure
- ☐ V.D.R.L.
- ☐ Sickle Cell Test
- ☐ Bacteriuria Screening
- ☐ Other (Specify)

13. INDICATE CATEGORY OF SERVICE
- 41 ☐ Primary Care Center
- ___ ☐ Other (Enter Code)

14. REFERRED TO:
01 ☐ PHYSICIAN 02 ☐ DENTIST ☐ OTHER (SPECIFY) _____

15. DISPOSITION OF CASE:
A ☐ NORMAL VISIT SCHEDULED B ☐ REFERRED FOR TREATMENT

16. Line No.	17. Provider Number	18. Place of Service Note (1)	19. Procedure/Supply Description PRESCRIPTION NUMBER	20. Drug Number	21. Units of Service	22. Procedure Supply Code	23. Tooth ID	24. See Note (2)	25. Procedure Charge	26. LEAVE BLANK
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

30. PROVIDER NAME AND ADDRESS

31. Provider Number

TOTAL CLAIM CHARGE	27.	39. LEAVE BLANK
AMOUNT FROM HEALTH INSURANCE	28.	
AMOUNT FROM MEDICARE	29.	

32. Authorized Certification and Signature

This is to certify that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and thay any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

33. COUNTY | 34. AREA | 35. INVOICE DATE ___ ___ ___ Mo. Day Yr. | 38. INVOICE NO.

36. Date of Service ___ ___ ___ Mo. Day Yr.

NOTE (1) PLACE OF SERVICE CODES
1. Doctor's Office
2. Patient's Home
3. Outpatient Dept. Hospital
4. Inpatient Hospital
5. Skilled Nursing Home
6. Primary Care Center
7. Intermediate Care Facility
8. Independent Laboratory
9. Rural Health Clinics/HMO

NOTE (2) Enter Diagnosis Treated from Block 10 "1" First "2" Second

37. CHARGE DISPOSITION
- ☐ Pay
- ☐ Charge Accumulate

TRANSMITTAL #17

AS OF 01/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 1

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
0231048	DONALDSON R	4834042135	9883324-552-580	111786	60.00	0.00	40.00	000
01 POS 6	PROCEDURE 09000				40.00		40.00	952
02 RX NO. 086510	DRUG CODE 0000300682				10.00		0.00	300
03 POS 6	PROCEDURE 08002				10.00		0.00	951

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 60.00 TOTAL PAID: 40.00

APPENDIX IX-A

TRANSMITTAL #17

AS OF 01/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4834042135	9883324-552-010	111786	30.00	262
01 POS 6	PROCEDURE 11122				30.00	262

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

APPENDIX IX-B

TRANSMITTAL #17

AS OF 01/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	8032450731	9883324-552-060	110286	32.00	260
574632	MITCHELL J	4324180114	9883324-552-020	110186	24.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 56.00

APPENDIX IX-C

AS OF 01/06/87

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	EOB
324789		4838021143	9883324-552-060	110486	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	40.00	0.00	40.00	0.00	40.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

AS OF 01/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: PRIMARY CARE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

262	THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260	ELIGIBILITY DETERMINATION IS BEING MADE
300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
951	THIS SERVICE IS NOT COVERED BY MEDICAID
952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT
999	REQUIRED INFORMATION NOT PRESENT

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)
2. Provider Name and Address	4. Medical Assistance Number
	5. Billed Amount / 6. Claim Service Date
	7. RA Date / 8. Internal Control Number

9. Provider's Message

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

_____ This claim paid on_____in the amount of_____.

_____ We do not understand the nature of your inquiry. Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

_____ This claim was denied on_____for EOB code _____

_____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other:_____

_____

_____

_____

_____

_____
EDS Date

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY		
2. Recipient Name	3. Recipient Medicaid Number		
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service	
	7. Billed Amt.	8. Paid Amt.	9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME:_____ PROVIDER #:_____

RECIPIENT NAME:_____MAID:_____

BIRTHDATE:_____ ADDRESS:_____

DATE OF SERVICE:_____TO_____ DATE OF ADMISSION:_____

DATE OF DISCHARGE: _____ NAME OF INS. CO.:_____

POLICY #:_____ CLAIM NO.:_____

AMOUNT OF EXPECTED BENEFITS:_____

MAIL TO: EDS
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O. Box 2009
Frankfort, KY 40602

MAP-250
(REV. 5/87)

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Press firmly to assure legible copies

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization), I explained to him/her the nature of the _____ (operation) sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

Date _____

3. State Agency, Program or Project

TRANSMITTAL #18

Completion of "Consent Form," MAP-250

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual being sterilized to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-250, "Consent Form" or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the recipient, the person obtaining the consent, and the physician according to Program policy. Refer to Section IV for Program policies pertaining to sterilizations.

2. General Instructions

The "Consent Form" (MAP-250) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-250 form:

-the surgeon, to attach to the primary care center's claim form;
-the assistant surgeon, to attach to the assistant surgeon's claim form;
-the anesthesiologist, to attach to the anesthesiologist's claim form;
-the hospital, to attach to the hospital claim form; and
-the patient.

Additional copies of the completed MAP-250 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-250 behind the corresponding claim form and submit for processing.

Order MAP-250 forms from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
Frankfort, KY 40621

Attention: Jim Garrison

3. Detailed Instructions for Completion of Form

a. Consent to Sterilization

This section must be completed at least 30 days prior to the sterilization procedure, except in cases of premature delivery and emergency abdominal surgery, in which cases a 72-hour waiting period is required. No more than 180 days may elapse between the date the form is signed and the date the procedure is performed.

Enter the name of the physician, center or the name of the physician and the phrase "and/or his/her associates" who expects to perform the procedure.

Enter the name of the procedure to be performed.

Enter the birthdate of the patient.

Enter the name of the patient.

Enter the name of the physician expected to perform the procedure.

Enter the method of sterilization.

The patient signs the form.

Enter the date the patient signs the form.

Race and ethnicity information may be designated by checking the appropriate block.

b. Interpreter's Statement

If appropriate, complete this section at the same time the above section is completed.

Enter the language used to read and explain the form.

The interpreter signs and dates the form.

c. Statement of Person Obtaining Consent

This section is completed at the same time or after the above two sections are completed.

Enter the patient's name.

Enter the procedure name.

The person obtaining the consent reads, signs, and dates the form. This date must be on or after the date the patient signed.

Enter the name and address of the primary care center employing the person obtaining consent.

d. Physician Statement

This section is completed at the same time or after the procedure is performed.

Enter the name of the patient and the date of the sterilization.

Enter the procedure performed.

Follow instructions on the form. Cross out the paragraph not used.

If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature on the Consent Form, check the applicable block and provide the information requested.

In the case of premature delivery, enter the expected date of delivery. The expected date of delivery must be at least 30 days after the individual's signature date.

If the procedure was performed as a result of emergency abdominal surgery, enter a brief description in the designated area of the Consent Form, or attach an operative report to describe the circumstances as required.

The physician who performed the procedure signs the form. The actual signature of the physician is required.

Enter the date the physician signs the form. This date must be on or after the date of the surgery.

MAP-251
(1-79)

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE

HYSTERECTOMY CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO HAVE A HYSTERECTOMY WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I, _____, have requested and received information about
(print or type)

hysterectomies (abdominal and/or vaginal) from _____.
(name of attending physician)

I was informed that a hysterectomy is the surgical removal of the uterus/womb and of the two (2) methods of performing the procedure (abdominal hysterectomy and vaginal hysterectomy).

I have been advised of the type of hysterectomy procedure (abdominal and/ or vaginal) that will be performed on me. I am aware of the complications that may result from the performance of this surgical procedure.

I was informed that a hysterectomy is intended to be a permanent/final and irreversible procedure. I understand that I will be unable to become pregnant or bear children.

I certify that I fully understand the above and voluntarily consent to the surgical procedure.

Signature of Patient/
Representative _____

Signature of Person
Obtaining Consent _____

Date _____

Completion of "Hysterectomy Consent Form," MAP-251

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual receiving a hysterectomy to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-251 or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the individual receiving the hysterectomy or her representative, except in circumstances described in Section IV of this manual.

2. General Instructions

The "Hysterectomy Consent Form" (MAP-251) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-251 form:

-the surgeon, to attach to the primary care center's claim form;
-the assistant surgeon, to attach to the assistant surgeon's claim form;
-the anesthesiologist, to attach to the anesthesiologist's claim form;
-the hospital, to attach to the hospital claim form; and
-the patient or her representative, for her records.

Additional copies of the completed MAP-251 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-251 behind the corresponding claim form and submit for processing. When a hysterectomy is performed on an individual who is already sterile, or who required a hysterectomy because of a life-threatening emergency, attach the physician's written certification behind the claim form and submit for processing.

(Rev. 2/84)

APPENDIX XV-A

Do Not Write in This Area

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE

EDS Federal
O. Box 2036
nkfort, KY 40602

MEDICAL ASSISTANCE STATEMENT
PRIOR AUTHORIZATION FOR VISION CARE
(Please press hard; you are making 3 copies)

1 RECIPIENT LAST NAME	2 FIRST NAME	3 M.I.	4 MEDICAL ASSISTANCE I.D. NO.	5 BIRTH DATE (MO.YR.)

6 SERVICE REQUESTED

A ☐ REPLACEMENT OF GLASSES
B ☐ REPLACEMENT OF LENS
C ☐ REPLACEMENT OF FRONT OR FRAMES
D ☐ TEMPLE REPLACEMENT OR HINGE REPAIR
E ☐ INITIAL

7 INDICATE REASON FOR REPLACEMENT

A ☐ DIAGNOSTIC CORRECTION
B ☐ FRAME BROKEN
C ☐ FRONT BROKEN
D ☐ (1) TEMPLE BROKEN
E ☐ (2) TEMPLES BROKEN
F ☐ (1) LENS BROKEN
G ☐ (2) LENS BROKEN
H ☐ (1) LENS SCRATCHED
I ☐ (2) LENS SCRATCHED
J ☐ LOST GLASSES
K ☐ OTHER _____ (SPECIFY)

8 IF PRESCRIPTION LENSES ARE REQUIRED, COMPLETE THE FOLLOWING

OLD RX	SPHERE	CYLINDER	AXIS	PRISM	BASE

	NEW RX	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD						
OS						

9 DESCRIPTION OF SERVICES REQUIRING APPROVAL	10 LINE NO.	11 PROCEDURE NO. TO BE BILLED
	1	
	2	
	3	
	4	
	5	
	6	

SIGNATURE OF OPHTHALMOLOGIST/OPTOMETRIST/OPHTHALMIC DISPENSER

DATE OF SERVICE

12 NAME AND ADDRESS OF OPHTHALMOLOGIST/OPTOMETRIST/
OPHTHALMIC DISPENSER

13 PROVIDER NUMBER

CAUTION: IN ORDER FOR YOU TO RECEIVE PAYMENT, RECIPIENT MUST BE ELIGIBLE ON DATE OF SERVICE. TO VERIFY, CHECK MEDICAID CARD.

DO NOT WRITE BELOW THIS LINE

14 ACTION TAKEN ON THIS REQUEST

☐ APPROVED DATE APPROVED ___ ___ ___ MO. DAY YR.

☐ DENIED
REASON FOR DENIAL:

15 PRIOR AUTHORIZATION TO BE USED ON CLAIM FORM

TRANSMITTAL #17

AUTHORIZED SIGNATURE

A. Prior Authorization

1. All services, other than examinations and diagnostic procedures, require prior authorization.

2. The limitation of two (2) complete pairs of eyeglasses per recipient per 12 months, requires prior authorization. This informs the provider what services will be payable by the KMAP. The approval of a Prior Authorization request has NO bearing on recipient Medicaid eligibility. The following guidelines should be adhered to by the provider when requesting authorization:

   a. Check the Medical Assistance card to determine if the recipient is eligible on the date seen by the provider. If so, determination of what the patient requires is made. This includes the examination and selection of frame, lenses, or any materials.

   b. The completed Prior Authorization Form, MAP-8, follows the instructions in this section. All parts of this form must be mailed to the following address for processing:

      EDS
      P.O. Box 2036
      Frankfort, KY 40602

      Please type or print in ink in order that entries are clearly marked on all required copies.

      EDS staff will determine if, and what, services are approvable. This will be indicated on the MAP-8 form, and a prior authorization number will be entered for any services granted approval. The yellow copy of the form will be returned to the provider.

c. Upon receipt of the yellow copy the provider can order the materials for those services that were granted approval.

IMPORTANT: Although the services were approved, reimbursement for materials will be made only if the recipient is eligible on the date the materials were ordered. It is the responsibility of the provider to verify the patient's eligibility. (Eligibility includes recipient name, MAID #, birthdate, and eligibility period.) Any materials ordered prior to the granting of approval by EDS are done so at the risk of the provider, as the services may be denied.

3. Completion of Prior Authorization

An example of a "Prior Authorization for Vision Care" form (MAP-8) is shown on Appendix XV-A. Instructions for the proper completion of this form are outlined below.

BLOCK
NUMBER

1. RECIPIENT LAST NAME:

Enter the last name of the patient EXACTLY as it appears on his current Medical Assistance Identification (MAID) card.

2. FIRST NAME:

Enter the first name of the patient EXACTLY as it appears on his current MAID card.

3. M.I.:

Enter the middle initial of the patient.

4. Medical Assistance I.D. Number

Enter the patient's identification number exactly as it appears on his current MAID card. The number consists of 10 digits and all of them must be entered.

5. Birth Date

Enter the month and year of the patient's birthdate.

6. Service Requested

Check appropriate box to indicate service(s) being requested. Note: If it has been over 12 months since last initial pair, and only the lenses are being requested, this is considered to be a request for a replacement of lenses, not an initial. The date of the last initial pair is to be entered as the reason for replacement. The dispensing service requested (initial/ replacement) must match the dispensing procedure code indicated. Each recipient can have only one initial pair per 12 months.

7. Indicate Reason for Replacement

Check the appropriate box(es) to indicate the reason(s) for the replacement. Each part being replaced must have a reason checked.

8. If Prescription Lenses are Required, Complete the Following

If lenses are required, enter the prescription in the box "New Rx." When new lenses are requested within 12 months due to diagnostic correction, both the old and new prescriptions must be entered. If new lenses are requested due to breakage or loss, and an examination was performed, enter the prescription in the box "New Rx." If no examination was performed to determine a new prescription enter the lens prescription in the box "Old Rx."

If the patient is photophobic and requires tint, this diagnosis must be entered.

9. Description of Services Requiring Approval

Enter a brief description of the service to be rendered and the supply item to be furnished to the patient.

When the patient is providing his/her own frames, for the initial pair of eyeglasses, indicate so in this area.

Signature of Ophthalmologist/Optometrist/Ophthalmic Dispenser

The actual signature of the provider (not a facsimile) is required, or a billing authority, i.e. billing clerk, may enter the provider name with their own initials entered on the same line. Stamped signatures are not acceptable.

Date of Service

Enter the actual date of service, not the date the form is completed and signed by the provider.

10. Line No.

No Entry Required.

11. PROCEDURE NO. TO BE BILLED

Enter the procedure code which identifies the service or supply item to be furnished.

If procedure codes are incorrect or missing, the form will be returned to the provider.

12. NAME AND ADDRESS OF OPTOMETRIST/OPHTHALMIC DISPENSER

Enter the complete name and address of the provider performing the services being requested on this form. Use of a rubber stamp is permissible.

13. PROVIDER NUMBER

Enter the 8-digit Medicaid provider number assigned to the provider indicated in block 12.

14. ACTION TAKEN ON THIS REQUEST

Leave blank. Program staff will complete this by indicating whether services were approved or denied, entering the date and signing the request form.

15. PRIOR AUTHORIZATION NO. TO BE USED ON CLAIM FORM

Leave blank. If approval is granted by EDS, the staff will enter the pre-authorization number assigned for this service.

16. Leave blank.

17. Leave blank.

18. No entry required.